Employer Account Information

Please return this form by fax/email to:
775 887-5040 – joanna@nvohc.com

Employer:_____	Phone Number: _____
Street Address:_____	Fax Number:_____
_____	Primary Contact:_____
_____	Email Address:_____
Workers Comp. Ins. Carrier (Name & Address):	**Policy Number:**_____
_____	Phone Number: _____
_____	Fax Number:_____
_____	Primary Contact:_____
Email Address:_____	Exp. Date:_____
Third Party Administrator (Name & Address):	Phone Number: _____
_____	Fax Number:_____
_____	Primary Contact:_____
	Email Address:_____
Additional Contact information and Reporting Requirements	

Please include a current Workers Compensation Insurance Certificate with this form.

Copies of this form are available at www.NvOHC.com

Nevada Occupational Health Center – 3488 Goni Road, Suite 141 – Carson City, NV 89706